WOODROW WILSON REHABILITATION CENTER
Fishersville, Virginia 22939-1500
Assistive Technology Referral Checklist

Name: Client's full legal name (last, first, middle) Referral Date: _____
Number: Client's Participant ID Number

GENDER: ☐ Male ☐ Female MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W ☐ E

ADDRESS: _____ HOME PHONE #: _____

_____ ALTERNATIVE #: _____

_____

SOCIAL SECURITY #: _____ BIRTH DATE: _____

NEXT OF KIN (and/or Incase of emergency please notify):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____ FAX: _____

REFERRED BY: _____ PHONE #: _____

REFERRAL ADDRESS: _____

_____

PHYSICIAN: _____ NPI #: _____

PHYSICIAN ADDRESS: _____

_____

PHONE #: _____ FAX#: _____

Disability: _____ Date of Injury/onset: _____

Who do you live with? ☐ self ☐ family members ☐ caregivers/attendant

Are you currently enrolled in Home Health? ☐ yes ☐ no
Services Currently Receiving**:** ☐ OT ☐ PT ☐ Speech ☐ Nursing/Wound Care
Name of Agency _____
Phone number of Agency _____

Are you currently enrolled in HOSPICE? ☐ yes ☐ no
Are you considering enrollment in HOSPICE? ☐ yes ☐ no

REASON FOR REFERRAL: ☐ repair ☐ replacement ☐ new

☐ Manual Chair ☐ Communication/AAC Device
☐ Power Chair ☐ Transfer/Lift Device
☐ Seating/Positioning ☐ ADL/Bath Equipment
☐ Scooter ☐ Ambulatory Device
☐ Other (specify): _____

Goal(s) / Purpose of Evaluation: _____

_____

INSURANCE/SPONSORSHIP: Do you have medical insurance? ☐ yes ☐ no

Medicare #: _____ and/or Medicaid #: _____

Name of Insurance Company: _____
Billing Address: _____
Telephone #: _____ Policy/Social Security#: _____
Policyholder Name: _____ Birth Date: _____
Type of Policy: ☐ GROUP ☐ INDIVIDUAL ☐ HMO POLICY
If Group Policy, please give GROUP #: _____

Employer Name: _____ Phone #: _____

Effective Date: _____ Calendar Year Policy: Y N If no, beginning date: _____

Percentage: In Network _____ Out of Network _____ Preexisting Clause? _____

Deductable: _____ Amt. Met: _____ Out of Pocket: _____ Amt. Met: _____

Lifetime/Calendar Max: _____ Deny if Medicare Denies: Yes No N/A

Pre-auth Required: Yes No

Nursing Home: _____ Map 122 Amt: _____ Social Worker: _____

MEDICAL HISTORY

Do you have current or recent problems with any of the following?

	YES	NO	UNSURE	
Present open skin areas (specify)	☐	☐	☐	_____
Newly healed skin breakdown (specify)	☐	☐	☐	_____
Broken Bones/Casts (specify)	☐	☐	☐	_____
Change in or new pain (specify)	☐	☐	☐	_____
Breathing problems (specify)	☐	☐	☐	_____
Loss or change of hearing (specify)	☐	☐	☐	_____
Current infections (MRSA, VRE, TB)	☐	☐	☐	_____

Comments: _____

Height: _____ (approx) Weight: _____ (approx)
Is weight stable: ☐ yes ☐ no ☐ increasing ☐ decreasing

AT Services Received Elsewhere and Status of Recommendations:

Facility: _____

☐ None ☐ Equipment on order ☐ In Process
☐ Not Done ☐ Completed but Need More ☐ None Made

Mobility/Positioning:
Check all that apply:
☐ Walks within the home ☐ Sits in wheelchair
☐ Falls ☐ Independently mobile in wheelchair
☐ Unable to Walk ☐ Depends on others for mobility

Wheelchair:
☐ Manual Brand/Model: _____ Size: _____ Year Obtained: _____
Serial Number: _____ Original Vendor: _____
☐ Scooter Brand/Model: _____ Size: _____ Year Obtained: _____
Serial Number: _____ Original Vendor: _____
☐ Power Brand/Model: _____ Size: _____ Year Obtained: _____
Serial Number: _____ Original Vendor: _____

☐ Tilt System ☐ Recline System ☐ Elevating Seat ☐ Elevating Legrests

How is chair propelled or driven?
Manual: ☐ Arms ☐ Legs ☐ Arm/leg ☐ One Arm ☐ Dependent
Power: ☐ Hand ☐ Chin ☐ Sip & Puff ☐ Head ☐ Switches ☐ Other ☐ Dependent

Problems: _____

_____

Seating-System:
☐ Cushion: Type _____ Size: _____ ☐ Custom molded seat

☐ Custom molded back ☐ Headrest ☐ Trunk supports ☐ Body jacket

How long can you sit? _____ ☐ Pain with sitting? ☐ Lose proper position?

Problems: _____

_____

Motor Function:
Indicate amount of useful movement:

Right arm/hand Function:	☐ Full	☐ Partial	☐ None
Left arm/hand Function:	☐ Full	☐ Partial	☐ None
Right leg/foot Function:	☐ Full	☐ Partial	☐ None
Left leg/foot Function:	☐ Full	☐ Partial	☐ None
Head/Neck Control:	☐ Full	☐ Partial	☐ None

Vision/Perception:
Visual Problems: ☐ none ☐ wears glasses ☐ Blurred (Close/Far) ☐ Double
☐ Bumps into Things ☐ Eyes jump around when looking at a stationary object
☐ Field Cuts ☐ Tunnel Vision

For AAC Referrals:

Social Interaction/Cognition:
Choose one which best describes level of alertness/interaction:
☐ Unresponsive to surroundings ☐ Onlooker; Observes ☐ Attempts Interactions
☐ Very Interactive

Can Client:

Sit and concentrate on a task	☐ Yes	☐ No
Follow directions/commands	☐ Yes	☐ No
Communicate clearly yes and no responses	☐ Yes	☐ No
Remember new/past information (memory)	☐ Yes	☐ No

Communication:
Current Communication Method:
☐ Verbal Speech --- Speech is understood by: ☐ Familiar listeners only ☐ All listeners
☐ Gestures ☐ Sign Language ☐ Communication Board/Book
☐ Augmentative Alternative Communication (AAC) Device (specify name or type of device):

_____

Is the Device still suiting your needs? ☐ yes ☐ no

Problems: _____

_____

Transportation:
Type: ☐ Car ☐ Family Van ☐ Public Transit ☐ Unavailable

Problems: _____

_____

OTHER

Comments or Additional Pertinent Information: _____

LOGISTICS:

Preferred days of the week to be seen: _____

Any specific dates you cannot come: _____

Who will be coming with you to this appointment: _____

Will your caregiver assist with toileting, transfers, and/or meals while at WWRC? ☐ yes ☐ no

How will you be transported to the appointment: _____

What is the contact number for your transportation: _____

Home Assessment:

Type of Home

☐ Single Story ☐ Multi-Story ☐ Apt./Condo ☐ Mobile Home

Handicap Accessible? ☐ Yes (ramps, stairs, elevator) ☐ No

Comments:

_____

_____

_____

Home Environment:
Are there any factors such as temperature, physical layout, surfaces, or obstacles that will render the MAE unusable in the beneficiary's home?

Bathroom	☐ Yes	☐ No	Comments: _____
Bedroom	☐ Yes	☐ No	Comments: _____
Kitchen	☐ Yes	☐ No	Comments: _____
Hallways	☐ Yes	☐ No	Comments: _____
Other rooms:	☐ Yes	☐ No	Comments: _____